

## GIVLAARI (GIVOSIRAN) ORDER FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 Patient has known difficult venous access. Comments: \_\_\_\_\_

### DIAGNOSIS (Provider must specify)

Adults with acute hepatic porphyria (AHP), ICD 10: E80.21  
 Other: \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics     Labs and tests supporting diagnosis     Office/progress notes

### PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV     Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Givlaari	2.5 mg/kg	Subcutaneous Injection	Monthly

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

### LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

**FAX NUMBERS:**

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> CT: 203.433.0621 | <input type="checkbox"/> MA: 413.296.8482 | <input type="checkbox"/> NC: 919.984.8698 | <input type="checkbox"/> NY: 631.250.6020 | <input type="checkbox"/> SC: 864.973.6279 |
| <input type="checkbox"/> FL: 904.877.9270 | <input type="checkbox"/> MD: 240.224.8607 | <input type="checkbox"/> NH: 603.217.5371 | <input type="checkbox"/> OH: 937.871.4594 | <input type="checkbox"/> VA: 703.202.0499 |
|   | <input type="checkbox"/> ME: 207.407.7272 | <input type="checkbox"/> NJ: 201.581.4521 | <input type="checkbox"/> PA: 610.273.5998 |   |